CHAPTER 8
SECTION 6

CLAIM DEVELOPMENT

1.0. GENERAL

1.1. The contractor shall use available in-house methods, i.e., contractor files, telephone, DEERS, etc. to obtain missing, incomplete, or discrepant information. If this is unsuccessful, the contractor may return the claim to the sender with a letter stating that the claim is being returned, stating the reason and requesting the missing or required information. The letter shall request all known missing or required documentation. The contractor's system shall identify the claim as returned, not denied. The Government reserves the right to audit returned claims as required, therefore the contractor shall retain sufficient information on returned claims to permit such audits.

1.2. If a claim is to be returned to a beneficiary who is under 18 years of age and involves venereal disease, substance or alcohol abuse, or abortion, the contractor shall contact the beneficiary to determine how he or she wishes to complete it. See Chapter 8, Section 8, paragraph 6.0. regarding possible contact procedures and the need for both sensitivity and use of good judgment in the protection of patient privacy. **Mail development shall not be initiated on this type of claim without consent of the beneficiary irrespective of whether it is a network or non-network claim**.

2.0. AGREEMENT TO PARTICIPATE

2.1. If the provider has agreed to participate, payment to the full extent of program liability will be paid directly to the provider, but the payment to the provider from program and beneficiary sources must not exceed the contractor determined allowable charge except as provided in payments which include other health insurance which is primary. In such a case, the provisions of 32 CFR 199.8 and the TRICARE Reimbursement Manual, Chapter 4 will apply.

2.2. In all cases in which the contractor has documented knowledge of payment by the beneficiary or other party, the payment shall be appropriately disbursed, including, when necessary, splitting payment. (See the TRICARE Reimbursement Manual for cases where double coverage is also involved.) If it comes to the contractor's attention that the terms have been violated, the issue shall be resolved as outlined in Chapter 14, Section 6, paragraph 7.0., under procedures for handling violation of participation agreements. If the provider returns an adjustment check to the contractor indicating that payment had been made in full, an adjustment check shall be reissued to the beneficiary/sponsor. If the non-network provider is clearly not participating or the intent cannot be determined, pay the beneficiary (parent/legal guardian).

3.0. CLAIMS FOR CERTAIN ANCILLARY SERVICES

If laboratory tests billed by a non-network provider were performed outside the office of the non-network provider, the place where the laboratory tests were performed must be provided. The contractor shall approve arrangements for laboratory work submitted by network physicians. To be covered, the services must have been ordered by an MD or DO and the laboratory must meet the requirements to provide the services as required under the 32 CFR 199, and TMA instructions.

4.0. V CODES

4.1. The ICD-9-CM codes listed in the Supplementary Classification of Factors Influencing Health Status and Contact with Health Services, otherwise known as V codes, deal with circumstances other than disease or injury classifiable to the ICD-9-CM categories 001-999. V codes are acceptable as primary diagnoses on outpatient claims (rarely on inpatient claims) to the extent that they describe the reason for a beneficiary's encountering the health care system. Claims with V codes as the primary diagnoses are to be processed as follows without development.

4.2. V codes which provide descriptive information of the reason for the encounter based on the single code, e.g., V03.X (Prophylactic vaccination and inoculation against bacterial diseases), V20.2 (Routine infant or child health check), V22.X (Supervision of normal pregnancy), V23.X (Supervision of high risk pregnancy) V25.2 (Contraceptive management), are acceptable as primary diagnoses. Claims with these codes may be processed according to TRICARE benefit policy without additional diagnostic information.

4.3. V codes for outpatient visits/encounters involving only ancillary diagnostic or therapeutic services are acceptable as the primary diagnosis to describe the reason for the visit/encounter only if the diagnosis or problem for which the ancillary service is being performed is also provided. For example, a V code for radiologic exam, V72.5, followed by the code for 786.50 (wheezing) or 786.50 (chest pain) is acceptable. If the diagnosis or problem is not submitted with a claim for the V-coded ancillary service and the diagnosis is not on file for the physician's office services, the claim is to be denied for insufficient diagnosis.

4.4. V codes for preventive services due to a personal history of a medical condition or a family history of a medical condition are acceptable as primary diagnoses when medically appropriate due to the personal or family history condition. Claims with these codes may be processed according to the TRICARE benefit policy without additional diagnostic information. Specifically, the treatment areas are as follows:

- Diagnostic and Screening Mammography, e.g., V725, V103, V1589 and V163.
- Pap Smears, e.g., V72.3, 76.2, and V15.89.
- Screening for Fecal Occult Blood, e.g., V10.00, V10.05 and V10.06.

4.5. Claims with the only diagnoses being V codes which do not fall into one of the above of categories, e.g., codes indicating personal or family histories of conditions, are to be returned for insufficient diagnosis. This includes those V codes corresponding to the V codes for "Conditions not Attributable to a Mental Disorder" in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

5.0. INDIVIDUAL PROVIDER SERVICES

Claims for individual providers (including claims for ambulatory surgery) usually require materially more detailed itemization than institutional claims. The claim must show the following detail:

- Identification of the provider of care;
- Dates of services;
- Place of service, if not evident from the service description or code, e.g., office, home, hospital, skilled nursing facility, etc.;
- Charge for each service;
- Description of each service and/or a clearly identifiable/acceptable procedure code; and
- The number/frequency of each service.

6.0. UNDELIVERABLE/RETURNED MAIL

When a provider's/beneficiary's EOB, EOB and check, or letter is returned as undeliverable, the check shall be voided.

7.0. TRICARE ENCOUNTER DATA DETAIL LINE ITEM - COMBINED CHARGES

Combining charges for the same procedures having the same billed charges under the contractor's "financially underwritten" operation, for TRICARE Encounter Data records, is optional with the contractor if the same action is taken with all. However, for example, if the claim itemizes services and charges for daily inpatient hospital visits from 03/25/2004 to 04/15/2004 and surgery was performed on 04/08/2004, some of the visits may be denied as included in the surgical fee (post-op follow-up). The denied charges, if combined, would have to be detailed into a separate line item from those being allowed for payment. Similarly, the identical services provided between 03/25 and 03/31, inclusive, would be separately coded from those rendered in April. The option to combine like services shall be applied to those services rendered the same calendar month.

8.0. CLAIMS SPLITTING

Under TEDs, a claim shall be split under the following conditions:

8.1. A claim covering services and supplies for more than one beneficiary (other than conjoint therapy, etc.) should be split into separate claims, each covering services and supplies for a specific beneficiary. This must be split under TEDs for different beneficiaries.

8.2. A claim for the lease/purchase of durable medical equipment that is paid by separately submitted monthly installments will be split into one claim for each monthly installment. The monthly installment will exclude any approved accumulation of past installments (to be reimbursed as one claim) due on the initial claim. Must be split under TEDs.

8.3. A claim that contains services, supplies or equipment covering more than one contractor's jurisdiction shall be split. The claim and attached documentation shall be

duplicated in full, and identification shall be provided on each document as "processed" by the contractor and then mailed to the other appropriate contractor having jurisdiction. The contractor splitting the claim, counts the remaining material as a single claim, and the contractor receiving the split material for its jurisdiction, counts it as a single claim, unless the split material meets one or more of the other criteria for an authorized split.

8.4. An inpatient maternity claim which is subject to the TRICARE/CHAMPUS DRG-based payment system and which contains charges for the mother and the newborn shall be split, only when there are no nursery/room charges for the newborn. See the TRICARE Reimbursement Manual, Chapter 1, Section 32.

8.5. Hospice claims that contain both institutional and physician services shall be split for reporting purposes. Institutional services (i.e., routine home care - 651, continuous home care - 652, inpatient respite care - 655, and general inpatient care - 656) shall be reported on an institutional claim format while hospice physician services (revenue code 657 and accompanying CPT codes) shall be reported on a non-institutional format. See the TRICARE Reimbursement Manual, Chapter 11, Section 4.

8.6. A claim for ambulatory surgery services submitted by an ambulatory surgery facility (either freestanding or hospital-based) may be split into separate claims for (1) charges for services which are included in the prospective group payment rate, (2) charges for services which are not included in the prospective group payment rate and are separately allowable, and (3) physician's fees which are allowable in addition to the facility charges. See the TRICARE Reimbursement Manual, Chapter 9, Section 1.

8.7. A claim submitted with both non-financially underwritten and financially underwritten charges shall be split. Non-financially underwritten charges shall be submitted as a voucher and financially underwritten charges shall be submitted as a batch.

9.0. PROVIDER NUMBERS

Claims received (electronic, paper, or other acceptable medium) with the provider's Medicare Provider Number (institutional and non-institutional) shall not be returned to the provider to obtain the TRICARE Provider Number. The contractor shall accept the claim for processing, develop the provider number internally, and report the TRICARE Provider Number as required by the TRICARE Systems Manual, Chapter 2, on the TED records.